Rhode Island Hospital
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BROWN UNIVERSITY
SCHOOL OF MEDICINE

Department of Neurology

Physicians Office Building
Suite 324
Providence, RI 02903
Tel 401 444-8806
Fax 401 444-8781
Email
edward_feldmann@brown.edu

Edward Feldmann, MD
Director
Cerebrovascular Laboratory
Rhode Island Hospital
Professor
Program in Neurology
Department of Clinical Neurosciences
Brown University
School of Medicine

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Valerie A. Murphy
Flynn & Associates
400 Crown Colony Drive
Suite 200
Quincy, MA 02169

Re: Paul T. Papadakis

Dear Ms. Murphy:

Thank you for asking me to examine and review the records of Paul Papadakis. I had the opportunity to see him November 14, 2005. I also had the opportunity to review the following: low back films from October 7, 1969, notes from a physician with initials EA beginning February 4, 1980, Mercy Emergency Room notes from June 8, 1983, notes from Dr. Steinberg beginning March 25, 1994, Conrail forms from April 19, 1994, notes from a physician with initials FHC beginning September 2, 1994, notes from Dr. Ebanks beginning May 20, 1994, notes from Dr. Rizzo beginning July 10, 1997, notes from Dr. Carrington beginning August 17, 1998, injury report from June 13, 2001, lumbosacral films from June 15, 2001 (actual films reviewed), notes from Dr. Carrington beginning June 27, 2001, notes from Dr. Field beginning June 28, 2001, lumbosacral MRI from July 7, 2001, notes from Dr. Kaye beginning August 28, 2001, notes from Dr. Khayala beginning August 30, 2001, notes from Dr. Pfeifer beginning March 20, 2002, lumbar MRI from April 23, 2002 (actual films reviewed), vocational assessment from July 13, 2004 and the records ended with a note by Dr. Carrington on August 8, 2005.

I obtained the following history and physical examination in my office. The patient is a 57 year old man with a low back injury in June of 2001. He attended the visit with his lawyer. I told him that this was an IME and I would not be assuming his medical care.

Medications include Nexium, Detrol LA, Effexor XR, Zocor, Xanax XR, Hydrocodone and Extra Strength Tylenol. He does not smoke or drink.

His father and mother are healthy. One sister has trouble with her pancreas. He has two healthy children. He has been out of work since the accident. He is a track inspector and maintenance foreman. This is heavy work.

Dr. Carrington is his primary physician. Review of systems is notable for high cholesterol, reflux, enlarged prostate with frequent urination, depression and anxiety since the accident of record, treated by his primary physician.

In 1997 he had bilateral carpal tunnel syndrome surgery. He was not 100% cured. His right hand has been intermittently symptomatic.

He had no prior back problems. He injured his neck in a car accident in 1993 but recovered 100%.

In June of 2001 he was driving a truck with steel wheels on the rails. One wheel broke and he used a bar to move the wheel. He twisted to the left and had a snap in his low back. Something cracked. He first sought medical attention on June 15. He saw his primary physician. He was also treated by a physiatrist, Dr. Cowan, Dr. Kaye, a pain management physician and another orthopedist.

He continues to have low back pain with burning in the center of the back and sharp pain radiating to the left sacroiliac area and buttock. The pain never went down the leg. He has no bowel or bladder symptoms. Bending makes his symptoms worse, but nothing helps. He has had two MRIs and x-rays. His diagnosis is an L4-5 torn disc and listhesis. He has been treated with physical therapy and injections. Surgery was not recommended. Standing or sitting for too long and driving are painful.

IDET was considered. This is intradiscal electrothermal therapy. It was not done because it is not proven to work and it was not covered by insurance. He has not gotten better or worse.

Losses include his job. He does not play golf, go deep sea fishing and can only do 30 to 60 minutes of yard work at a time. He lies on his left side with a pillow between his knees when he sleeps. He reads a lot. He lies on a recliner with his knees elevated.

On examination he was alert and oriented with normal language, memory and spatial ability by gross bedside observation. Cranial nerves II through XII were intact. He had bilateral carpal tunnel syndrome surgery scars. Tinel's sign was absent bilaterally. There was tenderness of the low back. Heel and toe walking were intact, although his gait was antalgic. Power, coordination, gait, station and tandem gait were otherwise normal. At 15 cm above the knee the thigh circumference was 45 cm bilaterally, while at 15 cm below the knee the calf circumference was 36 cm bilaterally. Reflexes were 2+ and symmetrical with bilateral flexor plantar responses. Cold, touch, vibration and position sense were intact. He had a tender area of he left upper buttock, the left buttock and the midline low back. There was no spasm. There was diminished range of motion of the low back.

He believed the history and physical covered the issues related to this injury.

Impression: With a reasonable degree of medical certainty, this patient developed low back pain after the accident of record. He never had clear cut nerve root symptoms. This was confirmed by my history. Physical examinations in the medical record identified signs of soft tissue injury. This was reiterated in my evaluation. The patient never had objective signs of neurological dysfunction. MRI reveals degenerative abnormalities of the lower back, with a tear of the L4-5

disc and bilateral L4 nerve root changes, which were not present on the second MRI.

In the absence of clear neurological symptoms and signs, the MRI abnormalities are degenerative in nature. The patient never had consistent neurological symptoms or objective signs to correlate with the MRI abnormalities. Therefore, this is the clinical presentation of a soft tissue injury which resolves over several weeks to several months.

I would be pleased to review the records of Dr. Cowan if you can make them available.

Sincerely,

Edward Feldmann, MD

EF/cmf